KANSAS PHYSICIAN/EMPLOYER REPORTING FORM

Please submit upon commencement of practice and yearly thereafter.

Physician:

Name: (please print) _____

Medical Practice Address: _____

_____

_____

County _____ Phone # _____

I hereby declare and certify that I, the undersigned, have practiced _____
Specialty

medicine at the above-stated address a minimum of 40 hours per week since _____
Date: mo/day/year

Complete only at the end of the 3-year contract: I will • will not • (*check one*) remain in this location to practice medicine.

_____ _____
Physician Signature Date

Employer:

I hereby declare and certify that Dr. _____ is employed by _____ at the above-stated address and provides at least 40 hours of _____ medicine per week.
Specialty

_____ _____
Signature Date

Subscribed and sworn to before me
this_____ day of_____, 200___.
Notary Public

DIVISION OF HEALTH
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